



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NORTH GARLAND SURGERY CENTER

Respondent Name

AMERICAN ZURICH INSURANCECO

MFDR Tracking Number

M4-17-3603-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim be paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Requestor's Supplemental Position Summary dated September 29, 2017: "Something went wrong on our calculations of code 28485. I show the total allowance should be \$4,034.87 and the at that time only paid \$1,156.19..."

Amount in Dispute: \$1,176.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is in the process of sending additional payment to the provider"

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2016	Ambulatory Surgical Care for CPT Code 28485-RT	\$877.68	\$877.68
	Ambulatory Surgical Care for HCPCS Code C1713	\$0.00	\$0.00
	Interest	\$299.20	See Order
TOTAL		\$1,176.88	\$877.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197-Payment denied/reduced for absence of precertification/authorization.
 - 199-Number of services exceed utilization agreement.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - W3-additional payment made on appeal/reconsideration.
 - 948-Re-reviewed at providers request with additional information and documentation additional payment suggested.

Issues

1. What is the applicable fee guideline?
2. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.
2. The requestor is seeking additional reimbursement of \$365.47 for CPT code 29827-RT.

28 Texas Administrative Code §134.402(d) states,

For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

CPT code 28485 is defined as "Open treatment of metatarsal fracture, includes internal fixation, when performed, each." The requestor appended modifier "RT-Right Side" to code 28485.

28 Texas Administrative Code §134.402(f)(1)(B) states,

The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

According to Addendum AA, CPT code 28485 is a non-device intensive procedure.

The Medicare fully implemented ASC reimbursement for code 28485 CY 2016 is \$1,339.58.

To determine the geographically adjusted Medicare ASC reimbursement for code 28485:

The Medicare fully implemented ASC reimbursement rate of \$1,339.58 is divided by 2 = \$669.79.

This number multiplied by the City Wage Index for Garland, Texas is \$669.79 X 0.9847 = \$659.54.

Add these two together \$1,329.33.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%

\$1,329.33 X 153% = \$2,033.87.

The total allowable for ambulatory surgical care services for CPT code 28485-RT is \$2,033.87. The respondent paid \$1,156.19. As a result, additional reimbursement is recommended of \$877.68.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$877.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$877.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	10/06/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.